FROM THE DESK OF

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Medicare for Railroad Families

The Federal Medicare program provides hospital and medical insurance protection for railroad retirement annuitants and their families, just as it does for social security beneficiaries. Part A (hospital insurance) is financed through payroll taxes paid by employees and employers, while Part B (medical insurance) is financed by premiums paid by participants and by Federal general revenue funds.

The following questions and answers provide basic information on Medicare eligibility and coverage, Medicare premium, deductible and coinsurance increases in 2005, as well as information on the changes in Medicare effected by legislation enacted in 2003.

1. Who is eligible for Medicare?

All railroad retirement beneficiaries age 65 or over, and other persons who are directly or potentially eligible for railroad retirement benefits, are covered by the program. Although the age requirements for some unreduced railroad retirement benefits are rising just like the social security requirements, beneficiaries are still eligible for Medicare at age 65.

2. Who is eligible for Medicare coverage before age 65?

In general, coverage before age 65 is available for disabled employee annuitants who have been entitled to monthly benefits based on total disability (i.e., the employee must have met the Social Security Act's requirements for a disability benefit) for at least 24 months. Disabled widow(er)s under 65, disabled surviving divorced spouses under 65, and disabled children may also be eligible.

Medicare coverage before age 65 on the basis of permanent kidney failure is also available to employee annuitants, employees who have not retired but meet certain minimum service requirements, spouses, and dependent children who suffer from permanent kidney failure requiring hemodialysis or a kidney transplant. (Special rules also apply for individuals diagnosed with Amyotrophic Lateral Sclerosis.)

3. How do persons enroll in Medicare?

If a retired employee or a family member is receiving a railroad retirement annuity, enrollment for both Part A (hospital insurance) and Part B (medical insurance) is generally automatic and coverage begins when the person reaches age 65. An individual may decline Part B if so desired, and this does not preclude him or her from applying for medical insurance at a later date. Premiums may be higher, however, if enrollment is delayed.

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If an individual is eligible for but not receiving an annuity, he or she should contact the nearest Board office about three months before attaining age 65 in order to apply for Medicare. (This does not mean that the individual must retire if presently working.) The best time to apply is during the three months before the month in which the individual reaches age 65. He or she will then have both hospital and medical protection beginning with the month age 65 is reached. If the individual does not enroll for Part B in the three months before attaining age 65, he or she can enroll in the month age 65 is reached or during the next three months, but there will be a delay of one to three months before medical insurance is effective. Individuals who do not enroll during their initial enrollment period may sign up in any General Enrollment Period (January 1 - March 31 each year). Coverage for such individuals begins July 1 of the year of enrollment.

4. How much can Medicare Part B premiums increase for delayed enrollment?

Premiums for Part B are increased 10 percent for each 12-month period the individual could have been, but was not, enrolled. However, individuals who wait to enroll in Part B because they have group health plan coverage based on their own or their spouse's current employment may not have to pay higher premiums because they are eligible for special enrollment periods. Nonetheless, individuals covered by an employer group health plan should consider how delaying enrollment will affect their eligibility for health insurance policies, known as "Medigap" insurance, which supplement Medicare coverage.

Individuals can get more detailed information about Medigap policies from the publications *Medigap Policies* or *Guide to Health Insurance for People with Medicare*. To get a copy, they can call the Medicare toll-free number 1-800-MEDICARE (1-800-633-4227) or go to www.medicare.gov on the Internet and click on "Publications."

5. What is covered by Part A (hospital insurance) of the Original Medicare Plan?

The hospital insurance program is designed to help pay the bills when an insured person is hospitalized. The program also provides payments for required professional services in a skilled nursing facility (but not for custodial care) following a hospital stay, home health services, and hospice care.

There is a limit on how many days of hospital or skilled nursing care Medicare helps pay for in each "benefit period." A benefit period begins the first day a patient receives services in a hospital. It ends after a person has been out of a hospital or other facility primarily providing skilled care for 60 days in a row.

Benefits are ordinarily paid only for services received in the United States or Canada. Hospital insurance also covers hospital stays in Mexico under very limited conditions.

6. What are the Medicare Part A deductible and coinsurance charges in 2004 and what will they be in 2005?

For the first 60 days in a benefit period, a Medicare patient is responsible for paying a deductible, which for 2004 is the first $876 of all covered inpatient hospital services. The Part A deductible will

increase to $912 in 2005. The daily coinsurance charge that a Medicare beneficiary is responsible for paying for hospital care for the 61st through the 90th day is $219 in 2004, increasing to $228 per day in 2005. If a beneficiary uses "lifetime reserve" days, he or she is responsible for paying $438 a day for each reserve day used in 2004, and $456 a day in 2005. Lifetime reserve days are an extra 60 hospital days a beneficiary can use if illness keeps him or her in the hospital for more than 90 days; a beneficiary has only 60 reserve days during his or her lifetime and the beneficiary decides when to use them.

In addition, the daily coinsurance charge a beneficiary is responsible for paying for care in a skilled nursing facility for the 21st through the 100th day is $109.50 in 2004 and will be $114 in 2005.

7. What are some of the services covered by Part B (medical insurance) of the Original Medicare Plan?

Medicare medical insurance helps pay for doctors' services and many medical services and supplies that are not covered by the hospital insurance part of Medicare, such as certain ambulance services, outpatient hospital care, X-rays, laboratory tests, physical and speech therapy, blood, mammograms, Pap smears, and colorectal cancer screening.

8. Will the Medicare Part B deductible and premium change next year and by how much?

The annual deductible for Medicare Part B will increase from $100 in 2004 to $110 in 2005. After that, the deductible will be indexed and subject to annual increases. After the deductible is paid, Medicare will generally pay 80 percent of the approved charges for covered services during the rest of the year; the beneficiary is responsible for paying the remaining 20 percent of the cost.

All beneficiaries currently pay the same basic premium amount for Medicare Part B ($66.60 in 2004 and increasing to $78.20 in 2005), which covers outpatient care and doctor visits. Beginning in 2007, the premium will increase for individuals with annual incomes of more than $80,000, and for couples with annual incomes of more than $160,000. The amount of the premium increase will be based on a sliding income scale.

9. What is not currently covered by the Original Medicare Plan?

The Original Medicare Plan provides basic protection against the high cost of illness, but it will not pay all health care expenses. Some of the services and supplies Part A or Part B cannot pay for are custodial care, such as help with bathing, eating, and taking medicine; dentures and routine dental care; most eyeglasses, hearing aids, and examinations to prescribe or fit them; long-term care (nursing homes); personal comfort items, such as a phone or TV in a hospital room; most prescription drugs; and routine physical checkups and most related tests.

10. What changes to Medicare were effected by the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003?

Among the major features of this legislation are provisions for Medicare coverage of prescription drugs, the establishment of a Medicare Advantage Program to replace the previous Medicare + Choice Program, and provisions for new preventive benefits.

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11. When will Medicare coverage for prescription drugs begin?

The actual prescription drug benefit will begin in 2006. In the interim, Medicare-approved drug discount cards became available in June 2004 to help beneficiaries save on prescription drugs. Medicare contracts with private companies to offer the drug discount cards which bear a Medicare-approved seal. Voluntary enrollment began May 2004 and continues through December 31, 2005.

The discount card program is not intended to be a prescription drug benefit, but rather a temporary discount program to help people without outpatient prescription drug insurance until the Medicare drug benefit takes effect on January 1, 2006.

In June 2004, Medicare also began providing a $600 annual credit towards the purchase of prescription drugs for Medicare beneficiaries with incomes in 2004 of not more than $12,569 for single individuals or $16,862 for married individuals. To qualify for the credit, beneficiaries must not be receiving outpatient drug coverage from other sources, including Medicaid, TRICARE, group or individual health insurance coverage, or the Federal Employees Health Benefits Program. Generally, once a person qualifies for the $600 credit, he or she is qualified until the new Medicare drug benefit begins.

The credit is reflected on the Medicare-approved drug discount cards of qualified beneficiaries. While Medicare-approved discount card programs can charge a beneficiary an enrollment fee of up to $30 per year, Medicare will pay the enrollment fee for beneficiaries who qualify for the $600 credit.

12. How will the Medicare prescription drug benefit work when it takes effect?

Beginning in 2006, all people with Medicare will be able to enroll in plans that cover prescription drugs. Plans might vary, but in general, this is how they will work:

- Beneficiaries will choose a prescription drug plan and pay a premium of about $35 a month.
- Beneficiaries will pay the first $250 (the deductible).
- Medicare then will pay 75% of the costs between $250 and $2,250 in drug spending. Beneficiaries will pay only 25% of these costs.
- Beneficiaries will pay 100% of the drug costs above $2,250 until they reach $3,600 in out-of-pocket spending.
- Medicare will pay about 95% of the costs after the beneficiary has spent $3,600.

Some prescription drug plans may have additional options to help pay the out-of-pocket costs.

Extra help will be available for people with low incomes and limited assets. Most significantly, people with Medicare who have incomes below a certain limit won't have to pay the premiums or deductible for prescription drugs. The income limits will be set in 2005. If a beneficiary qualifies, he or she will only pay a small co-payment for each prescription needed.

Other people with low incomes and limited assets will get help paying the premiums and deductible. The amount they pay for each prescription will be limited.

13. What is Medicare Advantage?

In 2004, the health plan option known as Medicare + Choice was replaced by the Medicare Advantage Program.

Congress created the Medicare Advantage Program to give beneficiaries more choices, and sometimes, extra benefits, by letting private companies offer them their Medicare benefits. Persons who join a Medicare Advantage Plan may have the following choices:

- Medicare Managed Care Plans;
- Medicare Preferred Provider Organization Plans, and;
- Medicare Private Fee-for-Service Plans.

If Medicare Managed Care Plans, Medicare Preferred Provider Organization Plans, or Medicare Private Fee-for-Service Plans are available in a beneficiary's area, he or she can join one and get Medicare benefits through the plan. By joining one of these Medicare Advantage Plans, beneficiaries can often get extra benefits, like additional days in the hospital. The plan may have special rules that they need to follow. They may also have to pay a monthly premium for the extra benefits.

Medicare Advantage Plans are available in many areas of the country. For information about the Medicare Advantage Plans available in a particular area, beneficiaries should call Medicare's toll-free number 1-800-MEDICARE (1-800-633-4227) or visit Medicare's Web site at www.medicare.gov.

14. What new preventive benefits are being offered?

Beginning in 2005, preventive benefits coverage will be expanded to include: a one-time initial wellness physical examination; screening blood tests for early detection of cardiovascular diseases; and diabetes screening tests for people at risk of diabetes.

15. Will Medicare be putting out information about these program changes?

The Centers for Medicare & Medicaid Services (CMS), the Federal agency responsible for administering Medicare, mailed letters to all Medicare beneficiaries in Spring 2004 to explain the prescription drug discount cards. In 2005, CMS plans to mail informational booklets to Medicare beneficiaries to explain the prescription drug benefits.

In the meantime, CMS will provide information about the Medicare-approved drug discount cards through the Medicare toll-free number 1-800-MEDICARE (1-800-633-4227), and through their Web site at www.medicare.gov.

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